28-52

Kansas Administrative Regulations
Kansas Department of Health and Environment

Notice to Reader

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Where possible KDHE will append changed regulations to the appropriate article. Once again, the lack of any attachments should not be construed as meaning there are no revisions.

Nothing contained herein should be construed as legal advice by KDHE. If you are not an attorney, you should secure competent counsel to interpret the regulations and advise you.

Office of Public Information
Kansas Department of Health & Environment

Notes

The *Kansas Register* notes the following changes:

28-52-2	New	V. 17, p. 168
28-52-3	New	V. 17, p. 168
28-52-4	New	V. 17, p. 168

will be equally applicable to all patients. At a minimum, the following provisions shall be included in the patients' bill of rights.

(a) Each patient shall have the right to choose care providers and the right to communicate with those providers.

(b) Each patient shall have the right to participate in planning of the patient's care and the right to appropriate instruction and education regarding the plan.

(c) Each patient shall have a right to request information about the patient's diagnosis, prognosis, and treatment, including alternatives to care and risks involved, in terms that the patient and the patient's family can readily understand so that they can give their informed consent.

(d) Each patient shall have the right to refuse home health care and to be informed of possible health consequences of this action.

(e) Each patient shall have the right to care that is given without discrimination as to race, color, creed, sex, or national origin.

(f) Each patient shall be admitted for service only if the agency has the ability to provide safe, professional care at the level of intensity needed.

(g) Each patient shall have the right to reasonable continuity of care.

(h) Each patient shall have the right to be advised in advance of the disciplines that will furnish care and the frequency of visits proposed to be furnished.

(i) Each patient shall have the right to be advised in advance of any change in the plan of care before the change is made.

(j) Each patient shall have the right to confidentiality of all records, communications, and personal information.

(k) Each patient shall have the right to review all health records pertaining to them unless it is medically contraindicated in the clinical record by the physician.

(l) Each patient denied service for any reason shall have the right to be referred elsewhere.

(m) Each patient shall have the right to voice grievances and suggest changes in services or staff without fear of reprisal or discrimination.

(n) Each patient shall have the right to be fully informed of agency policies and charges for services, including eligibility for, and the extent of payment from third-party reimbursement sources, prior to receiving care. Each patient shall be informed of the extent to which payment may be required from the patient.

(o) Each patient shall have the right to be free from verbal, physical, and psychological abuse and to be treated with dignity.

(p) Each patient shall have the right to have his or her property treated with respect.

(q) Each patient shall have the right to be advised in writing of the availability of the licensing agency's toll-free complaint telephone number. (Authorized by K.S.A. 65-5109; implementing K.S.A. 65-5104; effective, T-86-23, July 1, 1985; effective May 1, 1986; amended Feb. 28, 1994.)

28-51-112. **Home health aide training program.** (a) Each individual employed or contracted by a home health agency who is not licensed or professionally registered to provide home health services but who assists, under supervision, in the provision of home health services and who provides related health care to patients shall meet the training requirements of K.A.R. 28-39-171 through K.A.R. 28-39-174.

(b) This provision does not include individuals providing only attendant care services as defined at K.S.A. 65-6201 and amendments thereto. (Authorized by K.S.A. 65-5109; implementing K.S.A. 65-5115; effective, T-86-23, July 1, 1985; effective May 1, 1986; amended Feb. 28, 1994.)

Article 52.—MEDICAL CARE FACILITIES

28-52-1. **General requirements.** (a) Each medical care facility shall establish a written plan for risk management and patient care quality assessment on a facility-wide basis.

(b) The plan shall be approved and reviewed annually by the facility's governing body.

(c) Findings, conclusions, recommendations, actions taken, and results of actions taken shall be documented and reported through procedures established within the risk management plan.

(d) All patient services including those services provided by outside contractors or consultants shall be periodically reviewed and evaluated in accordance with the plan.

(e) Plan format. Each submitted plan shall include the following:

(1) Section I—a description of the system implemented by the facility for investigation and analysis of the frequency and causes of reportable incidents within the facility;

(2) Section II—a description of the measures used by the facility to minimize the occurrence of reportable incidents and the resulting injuries within the facility;

(3) Section III—a description of the facility's implementation of a reporting system based upon the duty of all health care providers staffing the facility and all agents and employees of the facility directly involved in the delivery of health care services to report reportable incidents to the chief of the medical staff, chief administrative officer, or risk manager of the facility;

(4) Section IV, organization—a description of the organizational elements of the plan including:

(A) Name and address of the facility;

(B) name and title of the facility's risk manager;

(C) description of involvement and organizational structure of medical staff as related to risk management program, including names and titles of medical staff members involved in investigation and review of reportable incidents;

(D) organizational chart indicating position of the facility's review committee as defined in K.S.A. 65-4923 and L. 1986, Ch. 229, New Section 4(a)(2); and

(E) mechanism for ensuring quarterly reporting of incident reports to proper licensing agency.

(5) Section V—a description of the facility's resources allocated to implement the plan; and

(6) Section VI—documentation that the plan as submitted has been approved by the facility's governing body.

(f) Plan submittal. On and after November 1, 1986, each medical care facility shall submit the plan to the department at least 60 days prior to the license renewal date. After an initial plan is approved, any amendments to the plan shall be submitted to the department.

(g) Departmental review. Upon review of the facility's risk management plan or any amendments the department shall notify the facility in writing if the plan of amendments have been approved or disapproved. The written notification will specify the reason for disapproval.

(h) Revised plan. Within 60 days of the date the facility receives notification the plan has been disapproved, the facility shall submit a revised plan to the department.

(i) Plan publication. The plan shall be disseminated to personnel in accordance with the plan. (Authorized by and implementing L. 1986, Chapter 229, Sec. 3; effective, T-87-50, Dec. 19, 1986; effective May 1, 1987.)

Article 53.—CHARITABLE HEALTH CARE PROVIDERS

28-53-1. **Definitions.** (a) "Agreement" means a written understanding between the department and a charitable health care provider regarding the rendering of professional services to medically indigent persons.

(b) "Department" means the Kansas department of health and environment.

(c) "Federally qualified health center" means a center which meets the requirements for federal funding under 42 USC section 1396d(1) of the public health service act, and which has been designated as a "federally qualified health center" by the federal government.

(d) "Indigent health care clinic" means an outpatient medical care clinic designed to provide care to the medically indigent under the medical direction of a qualified person licensed to practice medicine and surgery and licensed by the Kansas board of healing arts.

(e) "Local health department" means county, city-county and multi-county public health units established under the authority of K.S.A. 65-201.

(f) "Secretary" means the secretary of the Kansas department of health and environment. (Authorized by and implementing K.S.A. 1991 Supp. 75-6120; effective April 1, 1991; amended July 13, 1992.)

28-53-2. **Agreement.** (a) Each person applying for an agreement shall submit a completed application to the department on forms prescribed by the secretary.

(b) An agreement may be terminated by the secretary or the charitable provider with 30 days advanced written notice to the department. Failure of the provider to maintain proper licensure by the appropriate professional licensing agency shall constitute immediate cancellation of the agreement. (Authorized by and implementing K.S.A. 1991 Supp. 75-6120; effective April 1, 1991; amended July 13, 1992.)

28-53-3. **Eligibility criteria for medically indigent.** Persons shall qualify as medically indigent if they are:

(a) determined to be a member of a family unit earning at or below 200% of poverty income guidelines based on the annual update of "poverty income guidelines" published in the federal register by the United States department of health and human services;

(b) not indemnified against costs arising from medical and hospital care by a policy of accident and sickness insurance, an employee health benefits plan, a program administered by the state or federal government, or any such coverage; and

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28-52-2. Incident reporting. (a) Each medical care facility shall identify a written form on which employees and health care providers shall report clinical care concerns to the risk manager, chief of staff, or administrator. The original or complete copy of the incident report shall be sent directly to the risk manager, chief of staff, or administrator, as authorized in the facility's risk management plan.

(b) The risk manager, chief of staff, or administrator shall acknowledge the receipt of each incident report in writing. This acknowledgment may be made in the following manner:

(1) file stamping each report;

(2) (male symbol)intaining a chronological risk management reporting log;

(3) signing or initialing each report in a consistent fashion; or

(4) entering pertinent information into a computer database.

(c) Incident reports, investigational tools, minutes of risk management committees, and other documentation of clinical analysis for each reported incident shall be maintained by the facility for not less than one year following completion of the investigation. (Authorized by and implementing K.S.A. 65-4922; effective Feb. 27, 1998.)

28-52-3. Risk management committee. (a) Each medical care facility shall designate one or more executive committees responsible for making and documenting standard-of-care determinations with respect to each incident report, pursuant to K.A.R. 28-52-2. The jurisdiction of each risk management committee shall be clearly de-

lineated in the facility's risk management plan, as approved by the facility's governing body.

(b) The activities of each risk management committee shall be documented in its minutes at least quarterly, and this documentation shall demonstrate that the committee is exercising overall responsibility for standard-of-care determinations delegated by the committee to individual clinical reviewers and subordinate committees. (Authorized by and implementing K.S.A. 65-4922; effective Feb. 27, 1998.)

28-52-4. Standard-of-care determinations. (a) Each facility shall assure that analysis of patient care incidents complies with the definition of a ``reportable incident'' set forth at K.S.A. 65-4921. Each facility shall use categories to record its analysis of each incident, and those categories shall be in substantially the following form:

(1) Standards of care met;

(2) §andards of care not met, but with no reasonable probability of causing injury;

(3) §andards of care not met, with injury occurring or reasonably probable; or

(4) possible grounds for disciplinary action by the appropriate licensing agency.

(b) Each reported incident shall be assigned an appropriate standard-of-care determination under the jurisdiction of a designated risk management committee. Separate standard-of-care determinations shall be made for each involved provider and each clinical issue reasonably presented by the facts. Any incident determined by the designated risk management committee to meet category (a)(3) or (a)(4) shall be considered a ``reportable incident'' and reported to the appropriate licensing agency in accordance with K.S.A. 65-4923.

(c) Each standard-of-care determination shall be dated and signed by an appropriately credentialed clinician authorized to review patient care incidents on behalf of the designated committee. In those cases in which docu-

mented primary review by individual clinicians or subordinate committees does not occur, standard-of-care determinations shall be documented in the minutes of the designated committee on a case-specific basis. Standard-of-care determinations made by individual clinicians and subordinate committees shall be approved by the designated risk management committee on at least a statistical basis. (Authorized by and implementing K.S.A. 65-4922; effective Feb. 27, 1998.)

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and Environment

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